response or lack of response to medication, informing the student about their medications, oxygen administration via tracheostomy and ventilator care, enteral feedings, emergency interventions, individual health counseling and instructions, and other treatments ordered by the physician and outlined in the plan of care.

Qualifications of Providers:
The Licensed Practical Nurse and Registered Nurse shall be licensed by the State of Kentucky to provide the services and practice within the Kentucky Nursing Practice Act. Nursing services can be provided under 42 CFR 440.60 and on a restorative basis under 42 CFR 440.130 (d) including services delegated in accordance with the Nurse Practice Act and the Kentucky School Health Program Manual to individuals trained to perform delegated acts by a Registered Nurse.

Services provided by a health aide may only be provided under the following conditions:
1. Is under the supervision of an advanced registered nurse practitioner or a registered nurse;
2. Has been trained by an advanced registered nurse practitioner or registered nurse for the specific nursing service provided to a specific recipient; or
3. An advanced registered nurse practitioner or registered nurse has verified in writing that the aide has appropriate training and skills to perform the specific service in a safe, effective manner.

(g) Incidental interpreter services:
provided in conjunction with another covered service. These services will be provided based on state law requirements for appropriate specialties.

Incidental interpreter services are provided by an interpreter licensed by the Kentucky Board of Interpreters for the Deaf and Hard of Hearing.

(h) Orientation and Mobility Services:
Orientation and mobility services provide sequential instruction to individuals with visual impairment in the use of their remaining senses to determine their position within the environment and in techniques for safe movement from one place to another. The skills in this instruction include but are not limited to concept development, motor development and sensory development.

Orientation and mobility services are provided by an orientation and mobility specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or National Blindness Professional Certification Board (NBPCB).

(i) Respiratory Therapy Services:
Respiratory therapy are the procedures employed in the therapy, management, rehabilitation, gathering of assessment information, or other procedures administered to patients with deficiencies or abnormalities which affect their cardiopulmonary system and associated aspects of cardiopulmonary and other systems functions.

Respiratory therapy services are provided by a practitioner certified by the Kentucky Board of Respiratory Care.

4.b. EPSDT Services (continued)

F. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.

XXIX Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

(1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services), the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:

(a) 1905(a)(l), inpatient hospital services;
(b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
(c) 1905(a)(3), other laboratory and X-ray services;
(d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
(e) 1905(a)(5)(A), physicians services; 1 905(a)(5)(B), medical and surgical services furnished by a dentist;
(f) 1905(a)(6), medical care by other licensed practitioners;
(g) 1905(a)(7), home health care services;
(h) *1905(a)(9),* clinic services;
(i) 1905(a)(l0), dental services;
(j) 1905(a)(11), physical therapy and related services;
(k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
(I) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
(m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
(n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
(o) 1905(a)(1 7), nurse-midwife services;
(p) 1905(a)(18), hospice care;
(q) 1905(a)(19), case management services; and
(r) l905(a)(22), other medical and remedial care specified by the Secretary.

(2) For medically-necessary evaluative, diagnostic, preventive, and treatment services listed in Section 1905(a) of the Social Security Act included in an Individual Education Program under the provisions of the Individuals with Disabilities Education Act, the state shall pay in accordance with items (1) or (3), as applicable, except that for public providers the payment shall be a fee-for-service system designed to approximate cost in the aggregate without settlement to exact cost. The following describes the methodology utilized in arriving at the rates.

(a) Medicaid providers paid through the fee-for-service system are paid according to the Kentucky Medicaid Fee Schedule and its modifiers which are maintained by the department.

(b) Fee for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75% of estimated average charge.

(c) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid recipients, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time and other resources required to provide the particular service.

(d) Medicaid Services Provided in Schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP) or an Individual Family Service Plan (IFSP). Covered services include the following as described in Attachment 3.1-A pages 7.1.7(b)-7.1.7(e):

1. Audiology
2. Occupational Therapy
3. Physical Therapy
4. Psychological/Counseling Services
5. Speech
6. Nursing Services
7. Orientation and Mobility Services
8. Incidental Interpreter
9. Respirator Therapy

The interim payment to the Local Education Agencies for services (Paragraph (d) 1-6) listed above are based on the physician fee schedule methodology as outlined in Kentucky Medicaid Fee Schedule.

(e) Direct Medical Services Payment Methodology

Beginning, with cost reporting periods ending on or after July 31, 2008, the Department of Medicaid Services (DMS) will begin using a cost based methodology for all Local Education Agencies (LEAs). This methodology will consist of a cost report, time study and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

Once the first year's cost reports are received, and each subsequent year, the Department will examine the cost data for nursing services to determine if an interim rate change is justified.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts in Attachment 3.1-A pages 7.1.7(b) - 7.1.7(e).

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, capital outlay, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. Total direct costs for direct medical services from Item 1 above are reduced on the cost report by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.

3. The net direct costs for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the adjusted direct costs from Item 2 above.

   A time study which incorporates a CMS-approved methodology is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs.

4. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Kentucky public school districts use predetermined fixed rates for indirect costs. The Department of Education (KDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

5. Net direct costs and indirect costs are combined.

6. Medicaid's portion of total net costs is calculated by multiplying the results from Item 5 by the ratio of the total number of students with Medicaid Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP) receiving services to the total number of students with an IEP or an IFSP.

(f) Certification of Funds Process

Cost reports must be prepared and completed by each LEA on a quarterly basis to reflect the time study results for the quarter in which costs were incurred. On an annual basis, each provider will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(g) Annual Cost Report Process

For Medicaid services listed in Paragraph (d) 1-6 provided in schools during the state fiscal year, each LEA provider must complete an annual cost report. The cost report is due on or before April 1 following the reporting period.

Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by DMS or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Department, may be subject to penalties for non-

compliance. A 20% withhold of Medicaid payments will be imposed upon the delinquent provider 30 days after the Medicaid cost report filing deadline unless the provider has made a written request for an extension of the Medicaid cost report filing due date to DMS and has received a written approval from the DMS. The withholding of monies will continue until the Medicaid cost report filing requirements have been satisfied. Once, all requirements have been satisfied withheld monies will be released to the provider. Any monies withheld will not accrue interest to the benefit of the provider.

The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.

2. Reconcile annual interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual School Based Services (SBS) Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBS Cost Reports are subject to desk review by Division of Medical Assistance or its designee.

(h) The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual School Based Services (SBS) Cost Report. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

(i) The Cost Settlement Process

EXAMPLE: For services delivered for the period covering August 1, 2007, through July 31, 2008, the annual SBS Cost Report is due on or before April 1, 2009, with the cost reconciliation and settlement processes completed no later than July 31, 2010.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted. DMS will submit the federal share of the overpayment to CMS within 60 days of identification.

If the actual, certified costs of a LEA provider exceed the interim payments, DMS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

(3) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21, the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100 percent of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

(a) Any service described in one (1), above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
(b) 1905(a)(8), private duty nursing services;
(c) 1905(a)(20), respiratory care services;
(d) 1 905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under I 905(a)(6); and
(e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitariums, and personal care services in a recipient's home.

KENTUCKY SCHOOL BASED TIME STUDY

Introduction

The Department for Medicaid Services (DMS), Kentucky Department of Education (KDE) and individual schools wish to share in the responsibility for promoting access to health care for students in the public school system, preventing costly or long term health care problems for at risk students, and coordinating students' health care needs with other providers. Many of these activities, when performed by school staff, meet the criteria for Medicaid school-based administrative claiming and may be reimbursable.

The School-Based Administrative Claiming (SBAC) program is a federally funded program that allows schools to be reimbursed for some of their costs associated with coordinating school-based health services and providing Medicaid outreach activities. These activities are not claimable under the Medicaid School-Based "fee for service" program or under other Medicaid "fee for service" programs.

Unlike the "fee for service" program, the SBAC program does not require individual claims for each service rendered to or on behalf of a student and documentation of service. However, it is necessary to determine the amount of time school staff spend performing Medicaid administrative activities. As a result, participant school districts provide documentation through a quarterly time study process that specifically identifies the Medicaid and Non-Medicaid related activities being performed within each district. Time spent by district school staff on Medicaid administrative activities is captured through the use of randomly generated time samples that are generated and compiled for each day that school is in session. The results of time samples are then used in a series of calculations to determine the percentage of the school district's cost that can be claimed under the SBAC program. SBAC reimbursement to the school district is made from Medicaid federal funds.

Kentucky has 120 counties, 174 public school districts and 2 State owned schools. The State owned schools are referred to as the Kentucky School for the Deaf (KSD) and the Kentucky School for the Blind (KSB). The KSD is the only state owned schools participating in the SBAC. Currently 136 public school districts participate in the SBAC program with 130 public school districts participating in the Fee for Service (FFS) program(School Based Health Services (SBHS). The KSD participates in both the SBAC and SBHS programs.

Background:

Local Education Agencies (LEAs) and the KSD and KSB schools participating in the SBAC program in Kentucky must meet very specific requirements. Every agency, which intends to draw down SBAC reimbursement, must have an authorized interagency agreement, and participate in the SBAC uniform time study. Random Moment Time Study (RMTS) is believed to be more accurate and less administratively burdensome. CMS indicated "prior approval was not necessary for Kentucky to implement RMTS; however, if any changes are made to the proposed time study methodology which would result in an adjustment, the CMS-approved time study methodology will be applied retrospectively to any prior period costs and/or claims.

Program Organization:

The Kentucky Department of Medical Services (DMS) has interagency agreements with the Kentucky Department of Education (KDE).

- KDE serves as payment distribution agent for the Local Education Agencies (LEA) participating in SBAC
- KDE provides project administration and general oversight to the LEAs
- KDE provides technical assistance and claims review functions for the LEAs participating in SBAC.

- LEAs participating in SBAC enter into agreements with KDE to become SBAC participants.
- DMS oversees administration of SBAC, including payment of claims, issuing financial policy, and review of KDE monitoring efforts.

KDE contracts with a vendor to administer the SBAC. This contract period is for two (2) years with two (2) possible extensions. At the end of the extension period, the KDE will post a Request for Proposal (RFP) and conduct a bid process according to the purchasing regulations of the Commonwealth of Kentucky. The SBAC program is completely volunteer for the LEAs, and they have the option of dropping out at any time if they no longer want to participate in SBAC.

Time Study Methodology

The purpose of the time study is to (1) identify the proportion of administrative time allowable and reimbursable under the SBAC program and (2) identify the proportion of direct service time allowable and reimbursable under Medicaid to be used for Direct Service or Fee for Service (FFS) cost reporting to enable the State of Kentucky to conduct a cost settlement at the end of the state fiscal year for the FFS program.

In most school districts, it is uncommon to find staff whose activities are limited to just one or two specific functions. Staff members normally perform a number of activities, some of which are related to the direct covered services and some of which are not. Sorting out the portion of worker activity that is related to these direct covered services and to all other functions requires an allocation methodology that is objective and empirical (i.e., based on documented data). Staff time has been accepted as the basis for allocating staff cost. The federal government has developed an established tradition of using time studies as an acceptable basis for cost allocation.

A time study reflects how workers' time is distributed across a range of activities. A time study is not designed to show how much of a certain activity a worker performs; rather, it reflects how time is allocated among different activities. As stated previously, the state will utilize a Random Moment Time Study (RMTS) methodology at which time all LEAs who participate in both the SBAC and FFS programs will be required to participate in the RMTS methodology of time study.

Time Study Participants

All school districts that participate in the time study will identify allowable Medicaid direct service and administrative costs within a given district by having staff who spend their time performing those activities participate in a quarterly time study. These districts must certify that any staff providing services or participating in the time study meet the educational, experiential and regulatory requirements.

The following categories of staff have been identified as appropriate participants for the Kentucky time studies. Additions to the list may be dependent upon job duties.
The decision and approval to include additional provider types requires an amendment to the existing state plan, which would be submitted to CMS by DMS and involves CMS coverage staff, as well as, other federal review staff.

This does not include individuals such as parents or other volunteers who receive no compensation for their work; this would include in-kind "compensation". For purposes of this implementation plan, individuals receiving compensation from school districts for their services are termed "school district staff". Beginning with the October 2008 Quarter, Kentucky will begin using the two cost pool methodology. All staff will be reported into one of two cost pools: a Direct Service and Administrative Providers" cost pool and an "Administrative Services Provider Only" cost pool. **The two cost pools are mutually exclusive, i.e., no staff should be included in both pools.** The following provides an overview of the eligible categories in each cost pool.

Cost Pool 1 (Direct Service & Administrative Providers)

- Licensed Audiologist
- Licensed Speech / Language Therapist
- Licensed Speech / Language Therapist Assistants
- Licensed Occupational Therapists
- COTAs (Certified Occupational Therapy Assistants
- Licensed Physical Therapists
- Licensed Physical Therapy Assistants
- Advanced Registered Nurse Practitioner
- School Nurses, RN
- School Nurses, LPN
- Health Aide
- Licensed Clinical Social Workers
- Licensed Psychologist
- Licensed Psychological Practitioner
- Licensed Psychological Associate
- Licensed School Psychologist
- Certified Psychologist with Autonomous Functioning
- Certified Psychologist
- Licensed Professional Clinical Counselor
- Incidental Interpreter
- Orientation & Mobility Specialist
- Respiratory Therapist

Cost Pool 2 (Administrative Service Providers Only)

- School Social Workers
- School Counselors
- School Psychologist
- Psychologist Interns
- Special Education – Support Technicians
- Pupil Support – Technicians
- Special Education Administrators
- Pupil Support Services Administrators
- School Bilingual Assistants
- Health Services Special Education Teachers
- Interpreters & Interpreter Assistants
- And other groups/individuals that may be identified by the school district

Staff with job titles in both cost pools 1 & 2, are not automatically included in the time study. A district must determine whether they meet all requirements above and if they are less than 100% federally funded. Individuals that are 100% federally funded will be excluded from the time study. All criteria must be met in order to be included in the time study.

Two mutually exclusive time studies, described below, will be conducted for the Direct Services and SBAC programs. Although some staff may perform both direct services and SBAC related activities, they will only be allowed to participate in one of the two time studies. For Direct Service staff that also performs SBAC activities, the direct services time study will be used to identify the claimable activities for both programs. SBAC claimable time will only be included on a SBAC cost report and will not be reimbursed through the Direct Services Program. Each time study has two (2) cost pools that are made up as follows:

- The first cost pool is comprised of direct service staff, including those who conduct both direct services and administrative claiming activities as well as direct service only staff, and the respective costs for these staff.
- The second cost pool is comprised of administrative claiming staff only and the respective costs for these staff.

Therefore, the two universes of time study participants and associated cost pools are mutually exclusive and the only direct costs that can be claimed under Medicaid related to this program are derived from the two cost pools described above.

Random Moment Time Study (RMTS)

The RMTS method polls participants on an individual basis at random time intervals over a given time period and totals the results to determine work effort for the entire population of eligible staff over that same time period. The RMTS method provides a statistically valid means of determining what portion of the selected group of participant's workload is spent performing activities that are reimbursable by Medicaid.

TIME STUDY START AND END DATES

Each calendar quarter, the dates that school districts will be in session and for which their staff members are compensated will be determined. District staff members are paid to work during those dates that districts are in session: as an example, districts may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study. Each quarter, district calendars will be reviewed to determine those dates that the schools pay for their staff to work, and those dates will be included in the sample. Since school calendars change on an annual basis, the school calendars will be evaluated on an annual basis and the sample dates will be determined and documented.

Sampling Requirements (RMTS)

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary district administrative burden a consistent sampling methodology for all activity codes and groups will be used. The RMTS sampling methodology is constructed to achieve a level of precision of +/- 5% (two percent) with a 95% (ninety-five percent) confidence level for activities. This is in accordance with the Medicaid School-Based Administrative Claiming Guide of May 2003.

Statistical calculations show that a minimum sample of 2401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any invalid moments. Invalid moments are moments not returned or inaccurately coded.

The following formula is used to calculate the number of moments sampled for each time study cost pool:

$$ss = \frac{Z2 * (p) * (1-p)}{c2}$$

WHERE:

Z = Z value (e.g. 1.96 for 95% confidence level)
p = percentage picking a choice, expressed as decimal
(.5 used for sample size needed)
c = confidence interval, expressed as decimal
(e.g., .02 = ±2)

CORRECTION FOR FINITE POPULATION

Where:

pop = population

$$\text{new ss} = \frac{ss}{1 + \frac{ss-1}{pop}}$$

The following table shows the sample sizes necessary to assure statistical validity at a 95% confidence level and tolerable error level of 2%. Additional moments will be selected to account for unusable moments, as previously defined. An over sample of 15% will be used to account for unusable moments.

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2345	2697
200,000	2373	2729
300,000	2382	2739
400,000	2387	2845
500,000	2390	2849
750,000	2393	2852
1,000,000	2395	2854
3,000,000	2399	2859
>3,839,197	2401	2860

RMTS Process & Notification

The RMTS process is described here as four steps:

1. Identify total pool of time study participants
2. Identify total pool of time study moments
3. Randomly select moments; randomly match each moment to a participant
4. Notify selected participants about their selection

Identify Total Pool of Time Study Participants

At the beginning of each quarter, participating districts submit a staff roster (Participant List) providing a comprehensive list of staff eligible to participate in the RMTS time study. This list of names is subsequently grouped into job categories (that describe their job function), and from that list all job categories are assigned into one of two "cost pools" for each LEA participating in the time study. There will be two mutually exclusive cost pools.